touch with the right hand, and at the same time places his left hand on the patient's abdomen at the level of the umbilicus, while the right hand is engaged in exploring the deeper internal parts, the left hand is gradually passed downwards towards the pubis, and the fingers progressively depress the abdominal walls as in hypogastric palpation, being forced as deeply as possible into the cavity of the pelvis.

If the woman is thin and docile, this double manipulation is very easily accomplished, and the exploration of the uterus, especially, can be made absolutely complete. To succeed in this, the movement of the hands should occur simultaneously. The finger in the vagina, applied to the neck of the uterus, should be pushed upwards and backwards, so as to hold the womb firmly, while the left hand depressing the abdominal walls, and dipping deeply into the cavity of the pelvis, rests upon the back of the organ. The distance separating the two hands measures the dimensions of the womb, almost as exactly as could be determined by a necroscopic examination; at such a moment we can perceive the situation, surface irregularities, etc., of the organ examined.

In a general way, the uterus being in a state of physiological anteversion, the vaginal finger pressing not upon the inferior extremity of the neck, but upon its anterior wall, which is pushed upwards and backwards, determines a rocking movement in the inverse sense of the body. The fingers pressing upon the hypogastrium pushing its posterior face, and the distance that separates the two hands, indicates the thickness of the body of the organ and its true dimensions.

In case of deviation of the organ, it may happen that the uterus cannot be felt between the fingers of the right and left hand, which often seem to touch each other; we then investigate some other point in the pelvic cavity; this condition of affairs is most frequently found in the case of uterine flexion and notably in retroflexion, when the uterus is compressed between both hands, an elevating or lowering movement may be effected which will enable us to judge as to its partial or total mobility, either upwards, downwards or sideways. We are likewise able to determine by the sensations of pain developed in such movements the inflammatory alterations or reflex sensibility of the various portions of its suspensory ligaments.

By the same combined exploration, pressing always along the median line, we can learn the state of the bladder, and especially of the anterior and posterior cul-de-sac, note their condition and determine the presence of tumors. The vaginal finger perceiving the tumefaction which is held *in situ* by the left hand applied to the hypogastrium.

On the sides of the womb there are no organs to interfere, so the finger may be pushed along the lateral portions of the neck of uterus until it meets the fingers applied externally to the hypogastrium in such a way that the two hands feel each other; in a healthy condition of the uterus nothing will be be perceived.

If during this examination any foreign body is felt the surgeon should carefully investigate its nature, consistency, sensibility, and determine its seat and point of origin. Sometimes it may be a displacement of the uterus, sometimes a tumor of the large ligaments, and sometimes a disease of the fallopian tubes or ovaries. Ovarian lesions at their commencement can only be determined by bi-manual exploration, which not only reveals their existence, but enables us to establish their relation with neighboring organs, that which is of great importance viewed from an operative standpoint.

If we wish to make a detailed and complete examination, it is necessary to practice the vaginal touch with the right hand and hypogastric palpation with the left, in order to explore the median region and the right lateral half of the pelvis; on the contrary, if we wish to explore the left lateral half and the ovary on the same side, we should practice the touch with the left hand while the right hand is engaged in exploring the abdominal wall.

In conclusion, bimanual exploration is absolutely necessary in order to diagnose diseases of the uterus, fallopian tubes, ovaries, large ligaments and the pelvian peritoneum, and it is difficult to learn anything unless we resort to this combined examination each time that we practice the vaginal touch.

III. Rectal Touch.—The rectal touch should only be practiced in case of absolute necessity when the vaginal touch has discovered a uterine displacement or a pelvian tumor, the characteristics of which are obscure. The best thing to do under such circumstances is immediately to proceed, without warning the woman, to make the rectal touch—as if it were only a necessary part of the examination. The finger slowly withdrawn from the vagina is pushed rapidly into the rectum. The patient is perhaps slightly astonished, but the little emotion created soon passes away, and the examination is completed before the woman has a chance to offer any opposition. (Gallard.)

The pulp of the finger is directed forwards and passes over the anterior wall, across which it easily explores the genital organs, all of which are situated in front of the rectum. Thus, after passing the sphincters and entering the rectum the finger encounters in front a hard, smooth, rounded tumor, which is the neck of the uterus, and passing on to the posterior face of this organ we are enabled to examine its slightest peculiarities and penetrate the pelvic cavity even higher than by the vaginal touch. The flexions or curvatures of the womb, tumors having their seat on its posterior wall or those occupying the cul-de-sac of Douglas, are most easily examined, especially if we combine with the rectal touch hypogastric palpation, in the manner heretofore indicated. By the rectal touch we can most easily examine the ovaries.